



LOW BACK CLINIC

Specialized Care For Severe Neck & Back Pain

Application For Admission

If you are reading this you have been fortunate enough to qualify for a **consultation** at The Low Back Clinic. This however does NOT mean that your case has been accepted. Your consultation today will determine if your condition is serious enough to warrant you being a candidate for spinal decompression treatments.

Today's Date: _____

Name: _____ Sex: M F Age: _____ Birthday: ____/____/____

Address: _____ DD/MM/YYYY

City: _____ Province: _____ Postal Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____ Email: _____

Best place to reach you (please circle one): Home / Work / Cell May we leave a message for you? Yes / No

Employer: _____ Occupation: _____ Length of Employ: _____

Marital Status: S M W D Spouses Name: _____

Family Doctor's Name: _____ Phone: _____

How did you hear about The Low Back Clinic? _____

How serious do you think your back/neck problem is? _____

What is your main problem/symptom(s) prompting your request for a consultation with the Doctor today?

- Would you consider this problem (circle one)...
- MINIMAL (Annoying but causing NO limitations)
 - SLIGHT (Tolerable but causing a little limitation)
 - MODERATE (Sometimes tolerable but definitely causing limitations)
 - SEVERE (Causing Significant limitations)
 - EXTREME (Causing near constant (>80% of the time) limitations)

1. In spite of the fact that you are not a back specialist, you are in fact the person who knows more about your back than anyone else. In your own words and in your own opinion what do you think the real problem is?

2. How has your quality of life changed since your back became a problem?

3. What activities are you no longer able to do/limited in doing?

4. How long have you had this condition/problem?

5. Are you willing to live with this condition or are you at a point where you are ready to try to correct the problem?

6. What kinds of treatments have you tried previous to today?

Epidural: How Many: _____ When (approx): _____

Physical Therapy: How Long: _____ When (approx): _____

Medication(s): _____ When (approx): _____

Surgery: Type: _____ When (approx): _____

Other: _____

7. Did any of these treatments work? If so which one(s) and for how long?

8. What do you do on your own to alleviate the condition/pain?

9. What activities/movements are guaranteed to make the condition/pain worse?

10. Please describe the quality of the pain: (sharp, dull, achy, "toothache", shooting, stabbing, numb, tingling, etc...)

11. When is the pain at its worst? (Example: in the morning, as the day progresses, etc)

12. When is the VERY FIRST time you recall having this problem?

13. If you cannot find a solution to this problem what do you think will happen to you?

List in order of importance all OTHER Health Problems/Concerns NOT including Your Main Problem Above:

1. _____ How Long Have You Had This? _____
2. _____ How Long Have You Had This? _____
3. _____ How Long Have You Had This? _____
4. _____ How Long Have You Had This? _____

Please list ANY surgeries that you have had and the corresponding dates:

Surgery: _____ Date: _____ Surgery: _____ Date: _____
 Surgery: _____ Date: _____ Surgery: _____ Date: _____

In Reference to your MAIN PROBLEM how often are you aware of This Problem? (Please circle one)

Occasionally (25% of the time) Frequently (75% of the time)
 Intermittently (50% of the time) Constant (90-100% of the time)

Due to your Main Problem.....

Have you lost any time from work?	Yes	No	How Much Time? _____
Have you lost any time from your tasks at home?	Yes	No	How Much Time? _____
Have you lost any time from your family?	Yes	No	How Much Time? _____
Have you lost any time from your leisure activities? (Example: hobbies, travel, sports, etc)	Yes	No	How Much Time? _____

Considering the amount of pain/discomfort you've had THIS week, how long has your problem been this severe?

On a Scale of 0-10 (10 being unbearable, 0 being No Pain or Discomfort) Please rate the following:

The HIGHEST your pain gets WITHOUT medication: _____
 The LOWEST your pain gets WITHOUT medication: _____
 The HIGHEST your pain gets WITH medication: _____
 The LOWEST your pain gets WITH medication: _____

What are you hoping happens today as a result of your consultation with the Doctor?
